DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 0 5

2. STATE: South Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 01,2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902 (a)(13)(A), 1902 (a)(30) and 1923 of the SSA.
42 CFR § 447 sub part C.

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 0
b. FFY 2004 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 5,7 and 8.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 5,7 and 8.

10. SUBJECT OF AMENDMENT:
To establish written procedures for determining the individual hospital upper limit under South Dakota Disproportionate Share Hospital (DSH) Program, and to eliminate current language in the reimbursement methodology for psychiatric unit.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
James W. Ellenbecker

13. TYPED NAME:
JAMES W.ELLENBECKER

14. TITLE:
Department Secretary

15. DATE SUBMITTED:
6/27/03

16. RETURN TO:
Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre SD 57501-2291

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
JUN 30 2003

18. DATE APPROVED:
FEB 10 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brown for Smith.

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

5. Rehabilitation Units (only upon request and justification);
6. Children's Care Hospitals;
7. Indian Health Service Hospitals;
8. Hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994; and
9. Specialized Surgical Hospitals.

Payment for these in-state exempt facilities and/or units, except for psychiatric hospitals, psychiatric units, Indian Health Service hospitals, Specialized Surgical Hospitals, and instate hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994, will continue on the Medicare retrospective cost base system with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services that relate to exempt hospitals and units will be included as allowable costs.

2. Malpractice insurance premiums attributable to exempt units or hospitals will be allowed using 7.5% of the risk portion of the premium multiplied by the ratio of inpatient charges to total medicaid inpatient charges for these hospitals or units.

3. Psychiatric hospitals and psychiatric units will be paid on a per diem basis equal to the average per diem allowable costs for psychiatric hospitals and psychiatric units, as established by the State at $580.00 per day.

Indian Health Service hospitals will be paid on a per diem basis as established by HCFA.

Instate hospitals with less than 30 discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994 will be paid at 95% of billed charges.

Specialized Surgical Hospitals will be reimbursed on a per diem basis equal to twice the per diem rate allowable for swing-bed hospitals as established in Attachment 4.19-D, Section D - Other, Provision 10.

EXCEPTION TO PAYMENT METHODOLOGIES FOR ACCESS-CRITICAL AND AT-RISK HOSPITALS

Hospitals that have been determined by the Department of Health to be above average access-critical and above average at-risk will be reimbursed at the greater of actual allowable cost or the payment received under the provisions contained in this attachment.

UPPER LIMITS

Group 2: Psychiatric hospitals operated by the State of South Dakota.
Group 3: Other hospitals. (Any hospital not in Group 1 or 2.)

Payments to Group 1 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 1 hospitals qualifying under low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - **$14,100**

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - **$28,200**

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - **$42,300**

The amount of payment for each hospital is arrived at as follows:

The total number of facilities qualifying at greater than the mean, greater than one standard deviation above the mean, greater than two standard deviations above the mean, and greater than three standard deviations above the mean is determined. The total amount of funding budgeted for disproportionate share payments is then allocated starting with those facilities qualifying at greater than the mean. Facilities qualifying at greater than one standard deviation, greater than two standard deviations, and greater than three standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean. The payment amounts are adjusted until all the budgeted funds would be spent.

The proposed disproportionate share payment for each facility is then compared to the payment limit that has been established for each facility. If the payment limit is less than the proposed disproportionate share payment, then the payment limit amount will be the disproportionate share payment for that particular facility. The sum of the payments made to facilities where the payment limit was met is then subtracted from the total amount budgeted. The remaining budgeted funds are then allocated equally among the facilities where the payment limits have not been met. The subsequent allocation again is determined to insure that facilities qualifying at greater than one standard deviation, greater than two standard deviations, and greater than three standard deviations above the mean are paid double, triple, and quadruple, respectively, the amount for facilities qualifying at greater than the mean.

Payments to Group 2 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under low-income

utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - $100,000

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - $250,000

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - $500,000

if the qualifying rate is 3 or more standard deviations above the mean - $751,299.

Payments to Group 3 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - $250

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - $500

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - $750

if the qualifying rate is 3 or more standard deviations above the mean - $1,000.

If necessary, payments to qualified hospitals will be adjusted for the projected impact of the hospital's specific disproportionate share hospital payment limit as required by ORBA`93.

Disproportionate share payments will be made one time during each state fiscal year. If the total of disproportionate share payments to all qualified hospitals for a year is going to exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Act, the following process will be used to prevent overspending the limit. First, the amount of over-expenditure will be determined. Then the over-expenditure amount will be deducted from the total payments to Group 2 hospitals. Payments to individual Group 2 hospitals will be reduced based on their percentage of Group 2 total payments.